



Reporting Monthly Participation in Community Engagement Activities Granite Advantage Health Care Program

Use this form to report your monthly participation in one or more of the community engagement activities listed below. **DETAILED INSTRUCTIONS ARE ENCLOSED.** Please print all information in the spaces provided. Please note you can find your Medicaid ID Number (MID) in the lower left hand front corner of your blue Medicaid card that has **State of New Hampshire** on the front. If you are unable to locate your MID number, you may enter your birth date instead.

Name:	
Last _____	First _____
Medicaid ID#: _____	Date of Birth _____

By filling in the circle below to select activities and signing this form I attest, under penalty of unsworn falsification pursuant to RSA 641:3, that I participated in the qualifying community engagement activitie(s) indicated below for the hours stated and that all of the information that I have provided to the department is true to the best of my knowledge and belief.

Beneficiary Signature Date

FOR THE PARTICIPATION MONTH OF (MM/YYYY): _____

Community Engagement Activities	Total Hours Per Month
<input type="radio"/> Job Search and Job Readiness Enter total hours here >	_____
Please list the job search/job readiness activities that you participated in during the month and the number of hours for each activity. Enter the total number of hours for the month above.	
<input type="radio"/> Community Service, Volunteering, or Public Service Enter total hours here >	_____
Please list each place where you volunteered or provided community or public service during the month and the contact person, contact information (phone or email), date(s) and number of hours that you performed for each place. Enter the total number of hours for the month above.	

Community Engagement Activities		Total Hours Per Month
<input type="radio"/>	Caregiver Services For a Non-Dependent Relative Or Other Person With a Disabling Condition Enter hours here >
Please provide the name and contact information (phone or email) for the non-dependent relative or other person with a disabling condition for whom you provided caregiver services. Please describe the caregiver services that you provided and indicate the number of hours that these services were provided during the month. Enter the total number of hours for the month above.		
<input type="radio"/>	Participation in Outpatient Substance Use Disorder Services Enter hours here >
Please identify the agency or organization where you are receiving services. Enter the total number of hours for the month above. The hours recorded may not exceed 40 hours in a monthly period.		
<input type="radio"/>	Additional Work Hours Enter hours here >
If you worked more hours this month than you were automatically credited as shown in your status letter, enter the additional hours above. Please list the Employer's name, contact person, contact information (phone or email), date(s) and additional number of hours that you worked for each place you were employed during the month.		
<input type="radio"/>	Additional Self-Employment Hours Enter hours here >
If you worked more hours this month than you were automatically credited as shown in your status letter, enter the additional Self-Employment hours above. Please provide a description of the additional self-employment hours during the month.		

Instructions for Completing the Form

1. Enter your identifying information and sign and date the top section of the form. Please note you can find your Medicaid ID Number (MID) in the lower left hand front corner of your blue Medicaid card that has **State of New Hampshire** on the front. If you are unable to locate your MID number, you may enter your birth date instead.
2. Enter the month you are reporting activities for as a two-digit month and a four-digit year.
3. In the Community Engagement Activities section, completely fill in the circle to the left of the activity that you are reporting. If you have any questions regarding activities, a description can be found below.
4. Enter the total number of hours for the month in the far right column of the row which applies to the community engagement activity that you are reporting.
5. The beneficiary **MUST** return this form to the Department of Health and Human Services either by mail at the address above, by fax to (603) 271-5623 or by submitting the form through your NH EASY account, or bringing the form to a local district office. You can call 1-844-275-3447 (1-844-ASK-DHHS) if you have any questions.

Descriptions of Community Engagement Activities

Job Search and Job Readiness	This activity includes, but is not limited to, participation in job search or job training activities offered through the Department of Employment Security or through other job search or job readiness assistance program such as Workforce Innovation and Opportunity Act (WIOA) or Work Ready New Hampshire. Time spent in any assessment, training, enrollment or case management activity that is necessary for participation in this activity is credited toward job search and job readiness assistance hours. Attestation must include the type and duration of the activity.
Community Service or Public Service (Volunteer)	This activity requires attestation of where and when the community or public service was performed and the number of hours worked. The attestation must include contact information for the community service or public service agency.
Caregiver Services For a Non-Dependent Relative or Other Person With a Disabling Condition	This activity is for caregiving services provided to a non-dependent relative or other person with a disabling medical, mental health or developmental condition. It requires attestation by the beneficiary as to the services provided including the name of the non-dependent relative or other person with a disabling condition and the number of hours of caregiving services provided.
Participation in Outpatient Substance Use Disorder Services	This activity is for participation in ASAM Level 1 outpatient substance use disorder services, including medication assisted treatment, and recovery supports. It requires self-attestation of the number of hours that the beneficiary participated in the services up to 40 hours per month.
Additional Work Hours	A temporary increase in monthly employment hours for seasonal or other work that is above the beneficiary's average monthly employment hours may be reported as an activity. The reporting of additional employment hours as an activity under this section shall be limited to 2 consecutive months.
Additional Self-Employment Hours	This activity is for beneficiaries who are self-employed and work more hours than calculated by the department's eligibility system(s), the beneficiary shall report the additional hours worked.